OKLAHOMA
Employees Group
Insurance Division

Employees Group Insurance Division

Request for Insurance Premium Refund

Entity name _____ Group/Division # _____

Entity address _____

_____

Employee name _____ Member ID or SSN _____

Month/Year	Monthly Premium Paid	Monthly Premium Due	Refund Due
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
Total	$ 0.00	$ 0.00	$ 0.00

Reason for overpayment _____

_____

Insurance coordinator signature _____ Date _____

Note: Administrative Rule 260:50-3-8 (c): Refunds on behalf of employees shall be paid to the appropriate party. For an entity to receive a refund, the entity must have a credit balance.

Return completed form to: EGID, P.O. Box 11137, Oklahoma City, OK 73136-9998

EGID USE ONLY

V3 Transaction # _____

Approved for payment _____ _____
Supervisor Date

Approved for payment _____ _____
(If over $4,000 or six months) Member Accounts Director or Designee Date

FOR EGID USE ONLY

Revised 01/28/2022